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# TURBULENCE IN THE AMERICAN HEALTH CARE SYSTEM

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HALIFAX, NOVA SCOTIA

SEPTEMBER 15, 1983

(GREETINGS TO HOSTS, GUESTS)

IT'S A GREAT PLEASURE FOR ME TO BE HERE AND A PRIVILEGE TO REPRESENT OUR GOVERNMENT AND OUR SECRETARY OF HEALTH AND HUMAN SERVICES, THE HONORABLE MARGARET M. HECKLER. MAY I SAY THAT I AM ESPECIALLY PLEASED TO SHARE THE PLATFORM WITH AN ESTEEMED COLLEAGUE, MADAME MONIQUE BEGIN, THE MINISTER OF NATIONAL HEALTH AND WELFARE OF CANADA.

THE KEY WORD IN THIS 5TH BIENNIAL CONFERENCE IS "TURBULENCE." BUT I CAN TELL YOU THAT THERE ARE FEW PLACES ON EARTH WHERE THE WINDS OF RHETORIC ARE MORE TURBULENT THAN IN GENEVA, SWITZERLAND. AND IT WAS THERE, EARLIER THIS YEAR, DURING THE ANNUAL WORLD HEALTH ASSEMBLY OF THE WORLD HEALTH ORGANIZATION, THAT I HAD THE GOOD FORTUNE TO WORK SIDE-BY-SIDE WITH MINISTER BEGIN IN THE DEVELOPMENT OF REASONABLE STATEMENTS OF PURPOSE FOR THE IMPROVEMENT OF HEALTH AROUND THE WORLD.

THOSE W.H.O.-SPONSORED MEETINGS ARE VERY EDUCATIONAL. THEY HAVE TAUGHT ME HOW FAR THE WORLD HAS COME IN THE ACQUISITION OF KNOWLEDGE ...BUT HOW FAR WE HAVE YET TO GO IN THE EXERCISE OF WISDOM. I TEND TO LEAVE GENEVA AND HEAD FOR HOME WITH A SOUL CLOUDED WITH DISMAY AND SUSPICION, WERE IT NOT FOR THE FRIENDSHIP AND COLLEGIAL ADVICE OF DEDICATED MEN AND WOMEN SUCH AS MINISTER BEGIN.

SHE HAS, BY RIGHT, THE FIRST PLACE ON THE PROGRAM THIS EVENING. BUT, AS WE SAY DOWN SOUTH IN THE UNITED STATES, "SHE IS A TOUGH ACT TO FOLLOW." HOWEVER, LET ME RASHLY PROCEED AND OFFER TO YOU THIS EVENING A FEW PERCEPTIONS WE HAVE ABOUT THE NATURE AND THE SCOPE OF THIS "TURBULENCE" IN THE HEALTH CARE SYSTEM OF OUR COUNTRY.

FIRST, IF I MAY, LET ME SKETCH OUT SOMETHING OF A CONTEXT FOR MY REMARKS THIS EVENING. AND I'LL BE HONEST WITH YOU. IT'S A FAVORABLE CONTEXT. WE HAVE SOME PROBLEMS IN PUBLIC HEALTH...SOME SERIOUS ISSUES AND SOME VERY PUZZLING AND ALARMING MEDICAL MYSTERIES. BUT I BELIEVE THEY ARE NOW THE EXCEPTION. FOR THE MOST PART, THE CONTEXT OF HEALTH IN THE U.S. IS GOOD. LET ME QUICKLY GIVE THE OUTLINES OF WHAT I MEAN.

FOR THE PAST THREE DECADES WE HAVE BROUGHT ABOUT A CONSISTENT AND SIGNIFICANT DOWNWARD TREND IN OVERALL MORTALITY AND MORBIDITY. AS A PEOPLE, THE CITIZENS OF THE UNITED STATES ARE LIVING LONGER THAN EVER BEFORE, THEIR FEW ADDITIONAL YEARS OF LIFE ARE SPENT IN BETTER HEALTH THAN WAS THE CASE IN PREVIOUS GENERATIONS, AND -- AS A RESULT -- WE CAN ACCOMPLISH A GREAT DEAL MORE FOR OURSELVES, OUR FAMILIES, AND OUR SOCIETY.

SPECIFICALLY, THESE ARE SOME OF THE INDICATORS FOR THIS "CONTEXT OF HEALTH CARE":

° PERSONS NOW IN THEIR 30s CAN EXPECT TO LIVE ABOUT 6 YEARS LONGER THAN THEIR PARENTS...ABOUT 74 YEARS ON THE AVERAGE, RATHER THAN THE 68 YEARS OF A GENERATION AGO.

° DURING THE LAST 30 YEARS THE DEATH RATE FROM HEART ATTACKS HAS DROPPED BY 20 PERCENT...THE DEATH RATE FOR STROKE HAS COME DOWN BY 30 PERCENT...AND FOR PERSONS UNDER THE AGE OF 45, THE CANCER DEATH RATE HAS DROPPED BY 33 PERCENT.

° THE INFANT MORTALITY RATE IS AT 11.2 DEATHS PER 1,000 LIVE BIRTHS, THE LOWEST IN U.S. HISTORY AND IT IS STILL FALLING AT A STEADY RATE.

SO MUCH FOR THE "CONTEXT" OF OUR DISCUSSION. IN OTHER WORDS, WE CAN -- IN ALL GOOD CONSCIENCE -- FOCUS OUR THINKING ON THE COSTS OF CARE WITHOUT WORRYING TOO MUCH ABOUT THE RISKS TO THE HEALTH STATUS OF OUR PEOPLE. THAT STATUS IS GENERALLY GOOD AND IT'S GETTING BETTER.

BUT NOW WE MUST TURN TO THE DIFFICULT PART. DURING THE SAME PERIOD OF TIME WHEN WE HAVE BEEN MAKING SUCH GOOD PROGRESS IN HEALTH STATUS...THAT IS, FROM 1950 TO 1982...THE NATIONAL EXPENDITURES FOR HEALTH CARE ROSE FROM $12.7 BILLION TO $322 BILLION. THAT, MY FRIENDS, IS AN INCREASE OF 2,400 PERCENT! DURING THE SAME PERIOD OF TIME, THE CONSUMER PRICE INDEX FOR ALL GOODS AND SERVICES IN OUR ECONOMY WENT UP ONLY 300 PERCENT . SO WE CAN SAY THAT OVER THE PAST 30 YEARS THE UNITED STATES HAS HAD A NET INCREASE IN THE COST OF HEALTH CARE OF A LITTLE OVER 2,000 PERCENT!

NOW, LET ME ASK THE REALLY UNCOMFORTABLE QUESTION: "DID WE ACHIEVE A 2,000 PERCENT INCREASE IN HEALTH STATUS OR IN LIFE EXPECTANCY OR IN PRODUCTIVITY BETWEEN 1950 AND 1982?" IN ALL HONESTY, WE'D HAVE TO SAY, "NO, WE DID NOT."

AND THEREIN LIES A MAJOR PROBLEM FOR THOSE OF US WHO CARE ABOUT HEALTH IN THE U.S., AND WHO ALSO HAVE TO PAY FOR IT.

WE ARE UNEASY ABOUT THE RISING COSTS OF CARE, BUT I BELIEVE THE ROOT CAUSE OF OUR DISCOMFORT IS SIMPLY THIS: WE'RE NOT REALLY CLEAR ABOUT WHAT IT IS WE ARE BUYING.

WE HAVE A SERIOUS DEFINITIONAL PROBLEM WHICH CAUSES AS MUCH TURBULENCE AS ANY OTHER FACTOR I CAN MENTION. LET ME RECALL ONCE AGAIN OUR WORK IN W.H.O. AS YOU KNOW, THE INTERNATIONAL COMMUNITY ACCEPTS A DEFINITION OF HEALTH THAT INCLUDES TOTAL PHYSICAL, SOCIAL, AND MENTAL WELL-BEING. THAT MAKES A LOT OF SENSE, PARTICULARLY FOR THE GOVERNMENTS OF MANY DEVELOPING COUNTRIES. BUT FOR HIGHLY DEVELOPED COUNTRIES SUCH AS CANADA AND THE UNITED STATES, SUCH A DEFINITION PRESENTS A RADICAL ECONOMIC AND SOCIAL CHALLENGE.

BECAUSE OF THE GENERAL ACCEPTANCE OF THAT DEFINITION BY OUR PEOPLE, THE "HEALTH CARE SYSTEM," AS WE CALL IT, HAS BEEN DRAWN MORE AND MORE INTO STRUCTURING AND PAYING FOR AN INSTITUTIONAL RESPONSE TO ASTHMA AND THE FLU, TO HEART DISEASE AND COLONIC CANCER, TO DIVORCE AND ALCOHOLISM, TO STRESS AND ANGER, AS WELL AS TO EXTRA-HEPATIC BILIARY ATRESIA.

WE KNOW THAT MOST AMERICANS -- OVER 80 PERCENT -- BELIEVE THEIR HEALTH IS "GOOD" TO "EXCELLENT." THAT'S THE WAY THE ANSWERS TURN UP ON THE SURVEYS THAT ARE CONDUCTED YEAR IN AND YEAR OUT BY OUR NATIONAL CENTER FOR HEALTH STATISTICS. YET, 75 PERCENT OF ALL U.S. CITIZENS WILL VISIT A DOCTOR AT LEAST ONCE THIS YEAR. ONLY 12 OF THOSE PEOPLE WILL REALLY BE SICK ENOUGH TO BE HOSPITALIZED, AND OF THAT 12, ONLY ONE WILL DIE PREMATURELY. WHY DO THE OTHER 63 PERCENT GO TO THE DOCTOR? WHAT DO THEY WANT? AND WHAT IS IT THEY'RE PAYING FOR DURING THEIR VISITS?

I THINK WE HAVE TO DEAL WITH THIS ISSUE OF PUBLIC EXPECTATIONS OF MEDICINE, IF WE EVER WANT TO UNDERSTAND THE REAL ECONOMICS OF HEALTH CARE IN THE UNITED STATES. IT SEEMS CLEAR ENOUGH THAT THE PUBLIC BELIEVES IT CAN GET AN ANSWER FROM THE MEDICAL PROFESSION TO ALMOST ANY PERSONAL PROBLEM.

I SPECIFICALLY USED THE TERM "PERSONAL PROBLEM" RATHER THAN "HEALTH PROBLEM." I THINK THE DAYS HAVE NOW LONG SINCE PASSED WHEN PHYSICIAN AND PATIENT COME TOGETHER ONLY WITHIN THE NARROW CONFINES OF "HEALTH PROBLEMS."

MANY STATE GOVERNMENTS, FACED WITH SPIRALING MEDICAID COSTS, HAVE BEEN SHIFTING OVER TO THE CATEGORY OF "OPTIONAL HEALTH SERVICES" MANY SERVICES THAT WE WERE ROUTINELY PAYING FOR IN FORMER DAYS. THEY HAVE ALSO BEEN INCREASING THE LEVELS OF PATIENT COST-SHARING FOR DOCTOR'S OFFICE VISITS, WHEN THE MATTER AT HAND SEEMS TO BE OUTSIDE THE ACCEPTED OR TRADITIONAL ARENA OF "MEDICAL CARE."

THE PROBLEM OF DEFINITION IS ALSO AT THE HEART OF A VERY SPECIFIC APPROACH FOR REIMBURSEMENTS UNDER MEDICARE, A PROGRAM VITAL TO THE HEALTH OF NEARLY 30 MILLION AMERICANS. IT IS CALLED "PROSPECTIVE PAYMENT BY DIAGNOSIS-RELATED GROUPS" AND GOES INTO EFFECT ON OCTOBER 1ST.

UNDER THIS SYSTEM, MEDICARE WILL REIMBURSE HOSPITALS WITH FIXED PAYMENTS DETERMINED IN ADVANCE, REPLACING THE CURRENT COST-BASED METHOD OF PAYMENT. PAYMENTS WILL HENCEFORTH BE BASED UPON A PRE-SET RATE FOR THE KIND OF ILLNES TREATED. THE UNIT IS CALLED A DIAGNOSIS RELATED GROUP AND THERE ARE 467 OF THEM. FOR EXAMPLE...

- NUMBER 36 IS A RETINAL PROCEDURE...
- NUMBER 129 IS CARDIAC ARREST...
- NUMBER 238 IS OSTEOMYELITIS...
- NUMBER 419 IS A FEVER OF UNKNOWN ORIGIN...AND
- NUMBER 467, THE LAST OF THE GROUP, IS RESERVED FOR "OTHER FACTORS INFLUENCING HEALTH STATUS."

WE'VE COME A GOOD DISTANCE...BUT THERE IS STILL SOME DISTANCE TO TRAVEL, ELSE WHY WOULD WE NEED NUMBER 467.

AT ANY RATE, WE HOPE THAT, AS THIS SYSTEM IS PHASED IN OVER THE NEXT 3 YEARS, THE HOSPITALS IN OUR COUNTRY WILL BEGIN TO IMPROVE THEIR MANAGEMENT PERFORMANCE AND REAP THE DOLLAR REWARDS OF GREATER EFFICIENCY. FURTHER, WE BELIEVE THAT THE D.R.G. SYSTEM OF PROSPECTIVE PAYMENTS WILL ENSURE QUALITY SERVICE FOR MEDICARE BENEFICIARIES, WHILE COOLING DOWN THE FIRES OF INFLATION IN THE HOSPITAL SECTOR OF MEDICAL CARE.

THESE ACTIONS TRY, IN EFFECT, TO "CLOSE IN" THE DEFINITION OF "HEALTH" TO SOMETHING THAT IS MORE MANAGEABLE, MORE MEASURABLE, AND MORE REASONABLY REIMBURSABLE. WE BELIEVE THIS APPROACH WILL BE SUPPORTED BY THE PUBLIC, PARTICULARLY BY THE BENEFICIARIES OF OUR MAJOR HEALTH PROGRAMS, MEDICAID AND MEDICARE, AS IT HAS ALREADY BEEN SUPPORTED BY THE CONGRESS AND THE PRESIDENT.

BUT LET ME INJECT HERE THE NOTE OF TURBULENCE. THAT LIST OF 467 DIAGNOSIS RELATED GROUPS IS ONE OF MANY EXAMPLES OF THE HIGH DEGREE OF BIOMEDICAL SCIENCE WE HAVE ACHIEVED IN THIS COUNTRY. BUT, AS GOOD AS WE ARE, WE STILL DON'T HAVE ANY OFF-THE-SHELF SOLUTIONS TO PROBLEMS LIKE A.I.D.S., DIOXIN, ACID RAIN, GENITAL HERPES, OR ANOREXIA NERVOSA. NOR DO WE HAVE ANY "MAGIC BULLET" TO FIGHT ALCOHOLISM, SUICIDE, OBESITY, OR CHILD ABUSE. IN ITS COOLER, MORE LUCID MOMENTS, THE PUBLIC KNOWS THIS.

BUT I THINK WE'VE ENTERED A DIFFERENT PERIOD NOW, ONE IN WHICH WE MUST SHARE WITH THE LAY PUBLIC MORE AND MORE INFORMATION OF A HIGHLY SPECIFIC AND TECHNICAL NATURE -- AND WE MUST ENCOURAGE THEM TO ACT ON THAT INFORMATION. AND THIS NEW ELEMENT IN OUR NATIONAL HEALTH POLICY -- THAT OF ASKING THE PUBLIC TO SHARE RESPONSIBILITY FOR THEIR OWN HEALTH -- I BELIEVE WILL HAVE POSITIVE EFFECTS ON THE HEALTH STATUS OF AMERICANS FOR MANY, MANY YEARS TO COME.

THIS ISSUE OF SHARED RESPONSIBILITY IS PERVASIVE. IT IS AT THE HEART OF EACH OF THE 227 DISCREET OBJECTIVES IN OUR NATIONAL PROGRAM OF HEALTH PROMOTION AND DISEASE PREVENTION. HERE ARE JUST A FEW OF THE OBJECTIVES WE HOPE TO ACHIEVE BY 1990. IT IS NOT TOO DIFFICULT TO SEE HOW PUBLIC HEALTH AND THE AVERAGE CITIZEN MUST <u>BOTH</u> PARTICIPATE IN ORDER TO REACH THE OBJECTIVES:

* FOR EXAMPLE, WE WANT TO INSURE THAT 85 PERCENT OF THE AMERICAN ADULT POPULATION KNOWS THAT SMOKING IS A MAJOR RISK FACTOR FOR HEART DISEASE.

* WE HOPE TO LOWER THE PROPORTION OF ADULTS WHO SMOKE TO 25 PERCENT.

* WE WANT TO REDUCE THE INFANT MORTALITY RATE TO NO MORE THAN 9 DEATHS PER 1,000 LIVE BIRTHS.

* WE WANT TO REDUCE THE MOTOR VEHICLE FATALITY RATE FOR CHILDREN
UNDER AGE 15 TO NO GREATER THAN 5.5 PER 100,000 CHILDREN, OR A BIT MORE THAN HALF THE CURRENT RATE OF 9 PER 100,000.

I WON'T GO THROUGH ALL 227 OBJECTIVES. BUT I DO ENCOURAGE YOU TO BECOME FAMILIAR WITH THEM, AS THEY HAVE BEEN SET OUT IN THE PUBLICATION OF THE U.S. PUBLIC HEALTH SERVICE TITLED PROMOTING HEALTH/PREVENTING DISEASE: OBJECTIVES FOR THE NATION. THOSE OBJECTIVES WERE DRAWN, YOU MAY RECALL, FROM "HEALTHY PEOPLE," THE SURGEON GENERAL'S REPORT, PUBLISHED IN 1979.

IF YOU HAVEN'T SEEN THOSE TWO PUBLICATIONS, I STRONGLY URGE YOU TO DO SO. THEY OFFER NOT ONLY GOOD INFORMATION, BUT A VERY GOOD RATIONALE FOR PROCEEDING AS WE ARE ON A VARIETY OF FRONTS, AT ALL LEVELS OF GOVERNMENT, AND WITH THE FULL COOPERATION OF THE PRIVATE SECTOR. THEY ALSO HIGHLIGHT OVER AND OVER AGAIN THE PRIMARY ROLE TO BE PLAYED BY INDIVIDUALS AND FAMILIES THEMSELVES.

IN A SENSE, THESE TWO PUBLICATIONS SEEK TO BRING ABOUT A FAR MORE REALISTIC PERCEPTION OF INDIVIDUAL, FAMILY, AND COMMUNITY HEALTH THAN OUR SOCIETY HAS ENTERTAINED THUS FAR.

IN MY JUDGMENT, THE JOB OF SETTING OUT THOSE OBJECTIVES WAS ONE OF THE MOST IMPORTANT EFFORTS BY THE U.S PUBLIC HEALTH SERVICE IN RECENT YEARS. IF WE ACCOMPLISH THOSE OBJECTIVES, WE WILL HAVE ACTUALLY SAVED MORE LIVES, PROTECTED MORE PEOPLE, AND AT MUCH LESS COST THAN ANY PREVIOUS GENERATION HAS BEEN ABLE TO DO. AND IT WILL BRING ABOUT PROFOUND CHANGE IN THE HEALTH CARE ENVIRONMENT.

I BELIEVE THAT THIS WILL CONTINUE TO BE THE DIRECTION OF U.S. HEALTH POLICY IN THE YEARS AHEAD. WE REALLY HAVE LITTLE ALTERNATIVE, FOR TO CONTINUE THE WAY WE'VE BEEN GOING FOR THE PAST 20 YEARS CAN ONLY GUARANTEE MORE TURBULENCE IN THE YEARS AHEAD.

THE LAST MAJOR POINT I WOULD RAISE WITH YOU IS MUCH MORE DIFFICULT TO DESCRIBE, YET I BELIEVE IT IS FUNDAMENTAL TO OUR ULTIMATE SUCCESS IN CONTROLLING COSTS AND IMPROVING THE HEALTH STATUS OF OUR CITIZENS. THE PROBLEM HAS TWO PARTS TO IT:

* ARE WE DOING THINGS RIGHT?

* AND IF NOT, WHAT SHOULD WE BE DOING INSTEAD?

THE FIRST INVOLVES DOING A BETTER JOB OF EVALUATING OUR MEDICAL TECHNOLOGIES IN USE TODAY. THE SECOND PART INVOLVES DEVELOPING, THROUGH RESEARCH, THE MEDICAL TECHNOLOGIES OF TOMORROW.

ONE OF MY FAVORITE EXAMPLES OF A NEW AND COSTLY TECHNOLOGY IS BY-PASS SURGERY FOR VICTIMS OF HEART DISEASE. WE HAVE ADOPTED THIS NEW MEDICAL TECHNOLOGY AND USE IT QUITE EXTENSIVELY, EVEN THOUGH THERE IS STILL SOME QUESTION AS TO ITS EFFICACY IN ALL THE CASES IT'S BEEN USED SO FAR.

BUT EVEN MORE SIGNIFICANT IS THE FACT, THAT EVEN WITH THIS NEW AND EXPENSIVE TECHNOLOGY, WE HAVE COME NO CLOSER TO UNDERSTANDING THE NATURE OF HEART DISEASE. THE BY-PASS PROCEDURE IS ANOTHER WAY TO TREAT SYMPTOMS AND NOT CAUSES AND THAT IS ALWAYS THE MOST EXPENSIVE WAY TO GO. IT'S EXPENSIVE IN HUMAN AS WELL AS IN ECONOMIC TERMS.

SHOULD WE STOP BY-PASS SURGERY? SHOULD WE HAVE PROHIBITED ITS DEVELOPMENT? SHOULD WE NO LONGER REIMBURSE FOR IT? THE ANSWER IS "NO" TO ALL THESE QUESTIONS. BUT IT IS AN INADEQUATE ANSWER. IT SEEMS CLEAR ENOUGH THAT WE WILL NEVER REALLY GET CONTROL OF THE HIGH COSTS OF MODERN MEDICAL AND HEALTH CARE UNTIL WE CAST A COLD AND CALCULATING EYE UPON ALL OUR TECHNOLOGIES TO SEE WHICH ONES ARE REALLY WORTH PAYING FOR AND WHICH ONES NEED TO BE REPLACED WITH MORE AND BETTER INFORMATION.

SAD TO SAY, AS A SOCIETY, WE HAVE BECOME SO ACCUSTOMED TO THE "QUICK FIX" THAT WE ARE WILLING TO PAY HIGHER AND HIGHER PRICES FOR QUICKER AND QUICKER FIXES. AND WE SEEM TO BE TOTALLY UNCONCERNED THAT SUCH AN APPROACH IS REALLY <u>PART OF THE PROBLEM</u> AND HAS <u>LITTLE TO DO WITH A SOLUTION</u>.

NOW LET ME SPEND JUST A MOMENT OR TWO DEALING WITH THE TURBULENCE IN THE RESEARCH AREA, SINCE WE CAN'T POSSIBLE MAKE ANY PROGRESS IN THE HEALTH CARE ENVIRONMENT WITHOUT A GREAT DEAL MORE GOOD INFORMATION.

I CAN TELL YOU THAT THE UNITED STATES GOVERNMENT -- REGARDLESS OF WHO SITS IN THE WHITE HOUSE OR WHICH PARTY CONTROLS THE CONGRESS -- IS TOTALLY COMMITTED TO SUPPORT FOR RESEARCH. BUT WE HAVE COME TO REALIZE THAT, AS IMPORTANT A PRINCIPLE OF NATIONAL POLICY AS THAT MAY BE, IT IS NOT THE WHOLE STORY BY ANY MEANS.

I AM SOMETIMES AMAZED AT THE NUMBER AND VARIETY OF INTEREST GROUPS THAT CONTRIBUTE TO PROGRESS IN RESEARCH. AMONG THE MOST ACTIVE ARE THE ACADEMIC COMMUNITY...INDUSTRY...THE INVESTMENT COMMUNITY...AND GOVERNMENT. THEIR INTEREST IS NOT HARD TO EXPLAIN.

IF WE LOOK BACK AT 1982 FOR A MOMENT, WE WILL SEE THAT THE TOTAL INVESTMENT OUR SOCIETY MADE IN HEALTH RESEARCH THAT YEAR WAS $9.2 BILLION, MOST OF IT CARRIED OUT IN THE LABS AND TEACHING HOSPITALS OF OUR COLLEGES AND UNIVERSITIES. BUT OF THAT TOTAL, GOVERNMENT ACCOUNTED FOR ONLY 55 PERCENT. I SAY "ONLY" BECAUSE THE PUBLIC -- INCLUDING THE MEDICAL PROFESSION -- HAS THE IMPRESSION THAT VIRTUALLY ALL HEALTH-RELATED RESEARCH IS GOVERNMENT-FUNDED. BUT THAT'S NOT SO AT ALL.

AND EVEN THE GOVERNMENT SHARE IS NOT MONOLITHIC. IN FACT, IT IS NOT ONLY FEDERAL. A HALF BILLION OF THE 1982 TOTAL WAS SPENT BY THE STATES ON HEALTH-RELATED RESEARCH. THE FUNDS SUPPORT PROJECTS AT COLLEGES AND UNIVERSITIES, STATE HOSPITALS, INTRAMURAL STATE AGENCY LABS, AND PRIVATE CONTRACTORS, BOTH NON-PROFIT AND PROFIT-MAKING BUSINESSES.

THE FIGURES FROM 1982 ALSO REVEAL THAT PRIVATE INDUSTRY PUT $3.4 BILLION OF ITS OWN MONEY INTO HEALTH-RELATED RESEARCH. THE ECONOMY HAD NOT YET TURNED THE CORNER...THE STOCK MARKET WAS CERTAINLY BEARISH AT THE TIME...NEVERTHELESS, INDUSTRY DID MAKE THAT KIND OF COMMITMENT.

THE PRIVATE, VOLUNTARY SECTOR INVESTED ANOTHER $341 MILLION IN RESEARCH, MOST OF IT TARGETED TO SPECIFIC DISEASE CONDITIONS. FOR EXAMPLE, THE GROUP AT THE TOP OF THE LIST LAST YEAR WAS THE AMERICAN CANCER SOCIETY, WHICH SPENT $54.5 MILLION ON ITS OWN CANCER RESEARCH PROJECTS.

THESE INVESTMENTS BY THE PRIVATE SECTOR AS WELL AS THE PUBLIC SECTOR COMBINE TO MAKE A STRONG STATEMENT OF FAITH IN THE FUTURE OF OUR SOCIETY AND OF OUR ECONOMY. IN ADDITION, THEY SEEM TO REPRESENT THE EXTRAORDINARY "BALANCE OF INTERESTS" THAT HAS KEPT A SOCIETY LIKE THE UNITED STATES MOVING FORWARD FOR THE PAST TWO CENTURIES.

I MUST CONFESS THAT I DON'T REALLY KNOW HOW THIS BALANCE IS ACHIEVED. TO ME, AS A SURGEON, IT'S ALMOST A METAPHYSICAL PHENOMENON. I'LL LEAVE THE ANSWER TO THE SOCIAL SCIENTISTS AND HISTORIANS. THE CLOSEST EXPLANATION I CAN COME UP WITH IS THE FACT THAT THE MONEY FOR RESEARCH COMES FROM A VARIETY OF STRONG, COMPETING INTERESTS WHO -- THEMSELVES -- SEEM CAPABLE OF KEEPING EACH OTHER HONEST.

I HOPE THAT YOU MAY HAVE GLEANED FROM THIS OVERVIEW THAT WE HAVE AS MUCH TURBULENCE ACROSS THE HEALTH CARE LANDSCAPE AS DO OUR NEIGHBORS TO THE NORTH. BUT I THINK WE BOTH SHARE THE DETERMINATION TO TAME THE WIND AND WEATHER AND CALM THE FORTUNES OF GOOD HEALTH IN BOTH OUR COUNTRIES.

I THINK WE'RE DRIVEN TO IT BECAUSE FOR US THERE ARE NO ALTERNATIVES. I AM REMINDED OF THE WORDS OF RALPH WALDO EMERSON, THE GREAT NEW ENGLAND POET, ESSAYIST, AND PHILOSOPHER WHO NOTED IN HIS JOURNALS THAT "THE BLAZING EVIDENCE OF IMMORTALITY IS OUR DISSATISFACTION WITH ANY OTHER SOLUTION."

WE CAN SAY SOMEWHAT THE SAME THING. WE ARE SURELY GOING TO SOLVE THE PROBLEMS OF RISING HEALTH CARE COSTS BECAUSE WE ARE SIMPLY DISSATISFIED WITH THE ALL THE OTHER SOLUTIONS SO FAR.

THANK YOU.

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